



Root Cause Analysis (RCA)

The Basics

**A presentation for DBHDS
Licensed Providers**

Root Cause Analysis – The Basics

Goals of the presentation:

- To discuss the purpose of a RCA
- To review when to conduct a RCA
- To focus on the three components of a RCA required by DBHDS licensing regulations
- To offer approaches for finding root causes
- To explore how to make system changes based on a RCA

Root Cause Analysis – What is it?

Reference – 12VAC35-105-20. Definitions:

“Root cause analysis means a method of problem solving designed to identify the underlying causes of a problem. The focus of a root cause analysis is on systems, processes, and outcomes that require change to reduce the risk of harm.”

Root Cause Analysis – The Focus

The focus of a Root Cause Analysis is on prevention, not blame or punishment.

Root Cause Analysis – When is it required?

12VAC35-105-160.E

“A root cause analysis shall be conducted by the provider within 30 days of discovery for all Level II and Level III serious incidents”

Root Cause Analysis

Don't stop there!

You may decide to conduct a RCA at other times:

- Any unusual incident
- A series of related incidents. For example, medication errors that occur repeatedly on the same shift.

Providers may find that their quarterly review of Level I incidents reveals a trend or pattern. This is another opportunity to utilize this standard quality improvement tool.

Root Cause Analysis

Is it ever appropriate not to complete a RCA for Level II or III serious incidents?

- No, a provider must document a detailed description of the event to the best of their knowledge, understanding if the incident did not occur within their services or on their property they may have limited knowledge of the incident;
- Provider should conduct an analysis of why the event occurred and note if a determination is made that potential underlying causes of the incident were not under the control of the provider;
- It is important to note that some level of analysis is required to determine whether or not the incident was under the control of the provider.

Situation most likely to occur with Level III serious incidents.

Root Cause Analysis

Focus – system, processes and outcomes; not people

There may be situations however that staff will be disciplined.

Example - A serious incident is caused as a result of an intoxicated employee.

The provider would want to:

- Document what happened
- Determine whether there were underlying causes that were under the control of the provider.
- If identified, address those separately.
- Deal with the employee infraction through the Human Resources process

Root Cause Analysis

Licensing Minimum Requirements

12VAC35-105-160E.

The root cause analysis shall include at least the following information:

1. A detailed description of what happened
2. An analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and
3. Identified solutions to mitigate its reoccurrence

1. A detailed description of what happened.

- Step-by-step sequence of events leading up to an incident
- Actions taken immediately following the incident



Root Cause Analysis

Licensing Minimum Requirements

**2. An analysis of why it happened;
including identification of
underlying causes that were under
the control of the provider**

3. Identified solutions to mitigate its reoccurrence.

By finding the contributing factors or root cause of a system failure, a provider can then develop actions that will mitigate reoccurrence and sustain corrections.

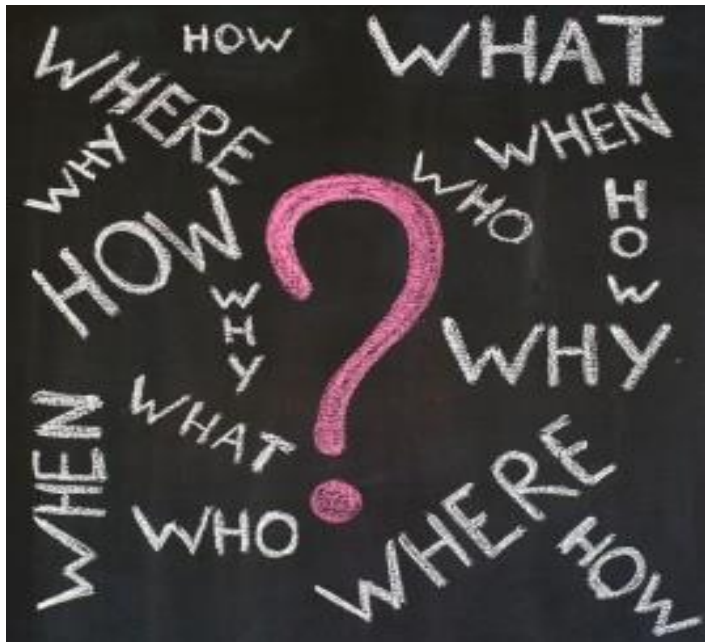
Who Will Conduct a RCA?

A single individual may conduct the RCA

Based on the circumstances of the incident, a team may be convened



Gather More Facts



**Interview
Those
Involved**



Interviews Matter

Ask the person being interviewed to:

- **Form a mental image of event.**
- **Remember & report every detail of setting & people.**
- **Describe what they remember.**

Don't:

- **Interrupt the person's train of thought.**
- **Be confrontational or threatening.**

Your role is to identify causes, not to lay blame.

What Should Have Happened?

Compare Actions to Policies and Procedures



What Do Experts Say?

Review Literature



Do I have the Root Cause?

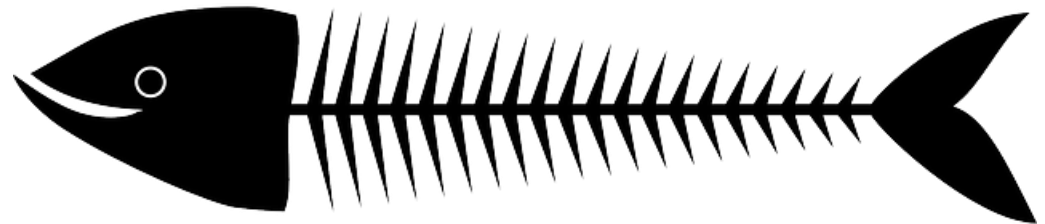
NO!

**Now you only have enough
information to state the
problem.**



Finding the Root Cause

WHY? WHY? WHY?
WHY? WHY? WHY?
WHY? WHY? WHY?


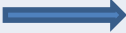

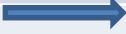



Example – Level II Incident

There were several individuals waiting in the outpatient lobby. All individuals were watching TV. Sarah entered the area and became agitated saying “the TV is too loud.” Sarah looked for the TV remote and began asking other individuals about the remote. Sarah began pacing and became agitated. Bill told Sarah they didn’t have the remote and to sit down. Given the number of individuals waiting, there were few chairs available.

Bill told Sarah to be quiet. Bill got up from his chair and Sarah tried to sit in his chair. The two individuals started pushing each other. Sarah fell and broke her ring finger.

5 Whys Worksheet

Problem Statement	One sentence description of incident, injury or problem:
Why?	
Why?	
Why?	
Why?	 
Why?	
Root Cause(s)	To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented?



Example Using 5 Whys Approach

Problem Statement – A fight occurred between two individuals in the outpatient lobby which resulted in an individual sustaining a serious injury.

Why did a fight occur?

Sarah became agitated because she said the TV was too loud.

Why was the TV too loud?

No one could adjust the volume.

Why couldn't anyone adjust the volume?

The remote was not in the lobby area. The receptionist controls the remote.

Example Using 5 Whys Approach

When responding to the Why questions, it is suggested to stop and ask “if the most recent response were corrected, is it likely the problem would recur?”

Example:

If you were to keep the remote in the lobby available to all individuals, would this prevent a similar incident from occurring?

No. It actually could cause more incidents. So this may be a contributing factor, but not the root cause.

Example Using 5 Whys Approach

Why didn't the receptionist turn down the TV?

The receptionist was not aware that Sarah wanted the TV volume changed or that the interaction between Sarah and Bill was escalating.

Why can't the receptionist see or hear Sarah or Bill?

The receptionist sits in an area that does not allow for line of sight for the entire lobby. She is behind a window which allows for privacy protection when dealing with PHI.

Fishbone Example

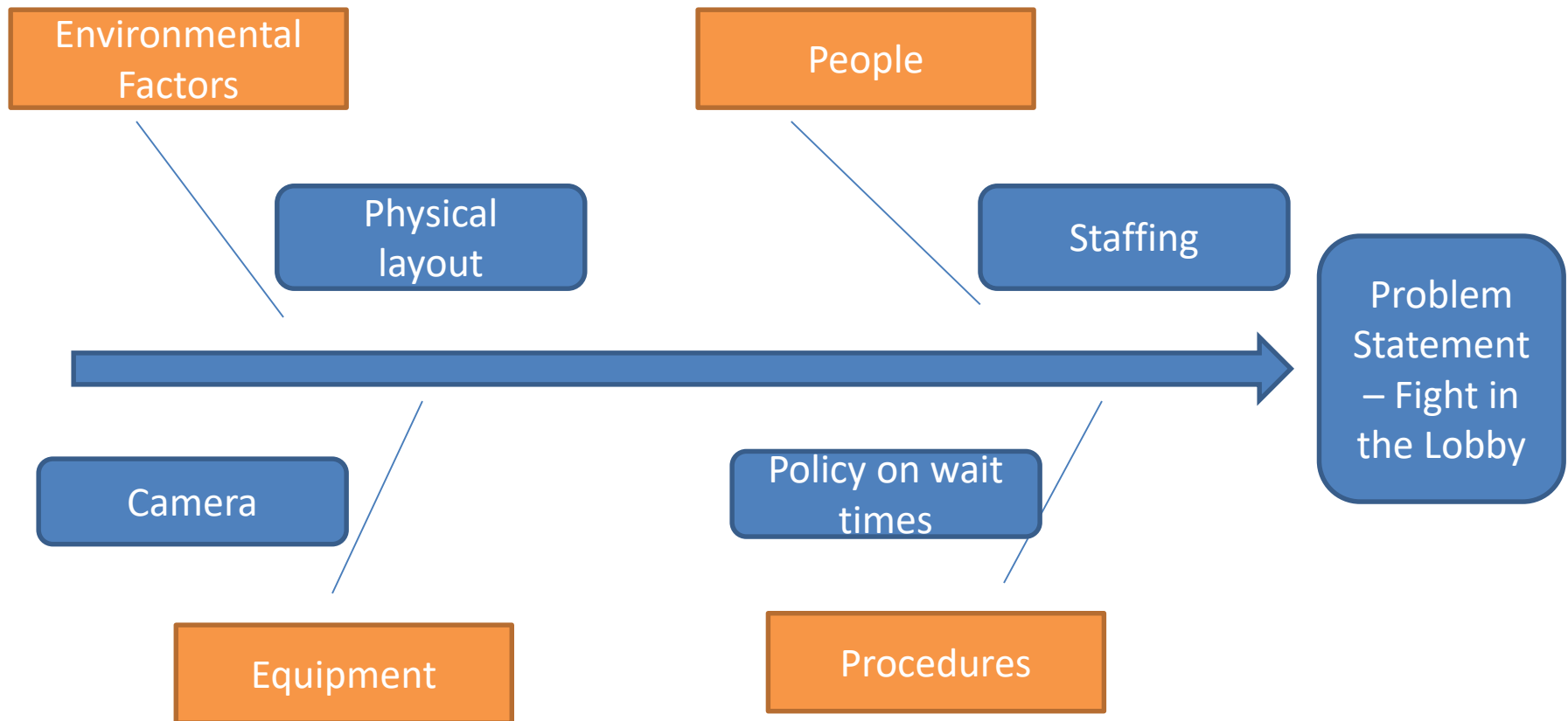
FISHBONE is:

- Cause and effect diagram
- Visual way to look at cause and effect
- The problem or effect is displayed at the head or mouth of the fish
- Possible contributing causes are listed on the smaller “bones” under various cause categories

*CMS Quality Assurance and Performance Improvement Toolkit

Using Fishbone Diagram

Same example using a fishbone diagram.



Root Cause Analysis - Solutions

Developing an Action Plan:

- **Root cause/contributing factor statement**
- **Action**
- **Outcome measure**
- **Responsible person**
- **Management concurrence**

Solutions to Mitigate its Reoccurrence

Solutions ideally focus on systems rather than individual factors

- Stronger actions
 - Environmental changes – changing equipment, physical plant
 - Simplify processes – removing unnecessary steps
 - Engineering controls – equipment can only be connected in the correct way; bar coding for medication administration

Solutions to Mitigate its Reoccurrence

Intermediate actions

- Increase staff or decrease workloads
- Eliminate or reduce distractions
- Implement checklists
- Standardized communications
- Improved documentation

Weaker actions

- Double checks
- Write/implement new procedure/policy/memo
- Staff training

Quality Improvement Plan

Action plans from root cause analysis can become part of a provider's quality improvement plan.

Caution – improvement requires change, but not every change is an improvement.

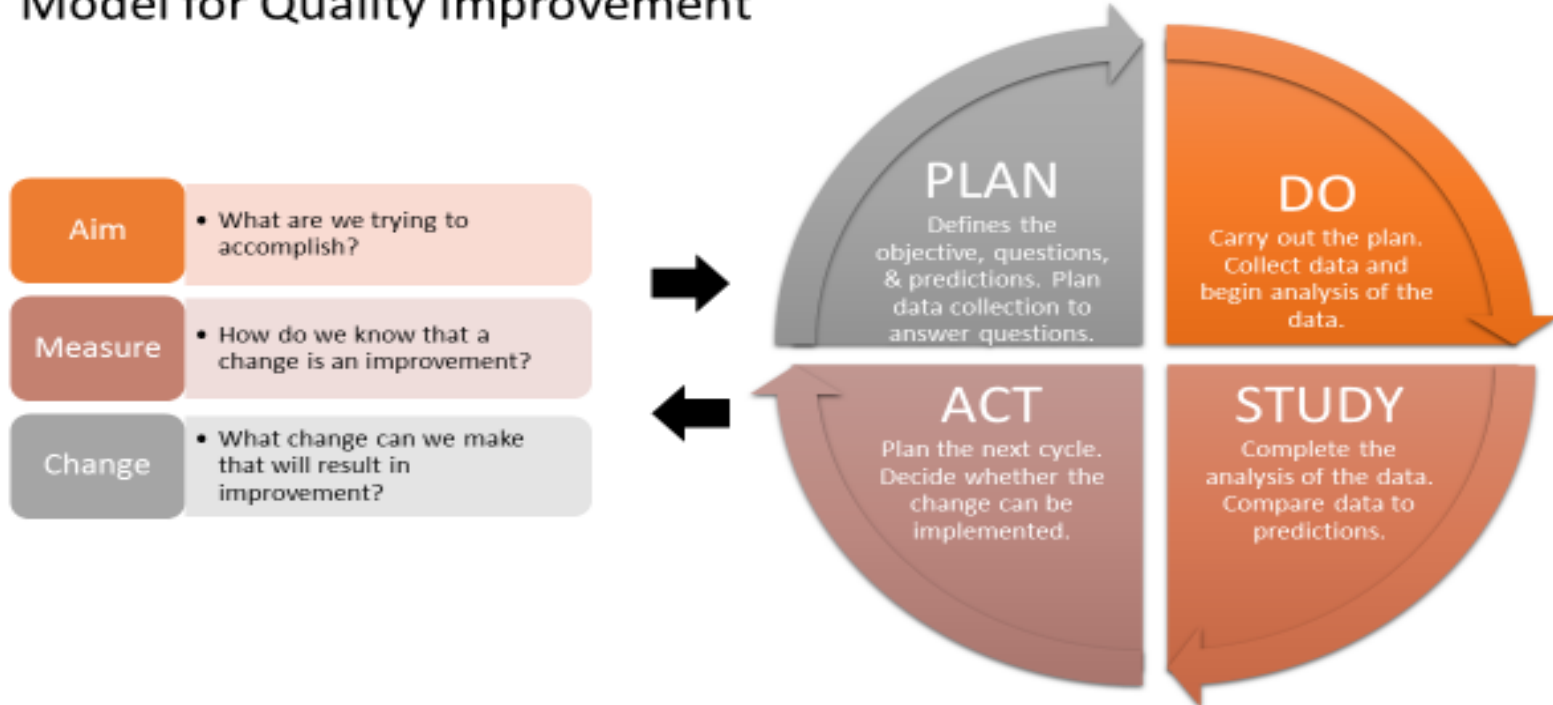


Organization should always monitor to determine if the recommended actions resulted in mitigating reoccurrence and the improvement is sustained.

Plan-Do-Study-Act (PDSA)

PDSA is a systematic testing of possible solutions, assessing the results, and implementing those which are shown to be successful.

Model for Quality Improvement



What Licensing Specialists will Look for During Inspections?

Proof that:

- Provider has a clearly documented process for when and how RCA will be conducted;
- Staff have been trained on how to complete a RCA;
- There is a completed RCA for each Level II and Level III serious incident;
- RCA clearly contains all required components;
- Changes are made as a result of RCA, as appropriate such as revised protocols or policies;
- If changes are not made, reasons why are clearly documented;
- Changes are clearly communicated to all staff at all levels; and
- Changes are monitored to ensure they are effective.

Summary

Licensed providers are encouraged to:

- ❖ Conduct RCAs in compliance with regulations
- ❖ Try different approaches for finding root causes (5 Whys or Fishbone Diagram)
- ❖ Make system changes based on the identified root cause(s)
- ❖ Sustain improvement(s) through monitoring and quality improvement plans

Resources

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FiveWhys.pdf